

Exhibit I
Inmate Medical File of Jeffrey B. Sanford

Part 2

HIV SEROLOGY 86701
WESTERN BLOT 86689

BUREAU OF CLINICAL LABORATORY

I.D. NUMBER

696042

PLEASE USE A BLACK PEN

Patient's Last Name		Patient's First Name		MI
Address		Apt.		Counselor (Initials)
Sanford, Jeffery Bernard				1-1-1
City	State	Zip	Date Collected	
1255	GA		03/05/2006	
Phone	B/M	EIA Results: Indicated by Marked		
		<input checked="" type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> Positive		
RACE		SEX	DOB (mmddyyyy)	
W B H A I U		M F		
Provider	SITE CODE		CNTY	
Address				
City	State	Zip		
County Health Dept. CHR Number	Social Security Number		ANALYST INITIALS	
Medicaid Number	Provider Number		DATE REPORTED	
			04/05/2006	
Has Patient Had a Previous Positive or Indeterminate Western Blot?		<input checked="" type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown		
Date				

Patient History Since 1978 of:		No	Yes	Medicaid Information	
Donated Blood, Plasma or Sperm		<input type="radio"/>	<input checked="" type="radio"/>	Patient Tested: <input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unk	
Received Blood Transfusion/Products		<input checked="" type="radio"/>	<input type="radio"/>	Pre-test Counseling: <input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unk	
Occupational Exposure To Body Fluids		<input type="radio"/>	<input checked="" type="radio"/>	Reason:	
Hemophilia		<input checked="" type="radio"/>	<input type="radio"/>	Re-test: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unk	
Possible Perinatal Transmission		<input checked="" type="radio"/>	<input type="radio"/>	Reason:	
History of Sexually Transmitted Disease		<input type="radio"/>	<input checked="" type="radio"/>	Post-test Counseling: <input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unk	
Non-IV drug use (including alcohol)		<input type="radio"/>	<input checked="" type="radio"/>	Reason:	
IV drug use		<input checked="" type="radio"/>	<input type="radio"/>	04/11/2006	
Multiple Sex Partners		<input type="radio"/>	<input checked="" type="radio"/>		
Exchanged sex for money or drugs		<input type="radio"/>	<input checked="" type="radio"/>		
Victim of physical abuse or sexual assault		<input checked="" type="radio"/>	<input type="radio"/>		
SEXUAL ORIENTATION				Referral	
<input type="radio"/> Homosexual <input checked="" type="radio"/> Heterosexual <input type="radio"/> Bisexual				TB Skin Test: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unk	
Sexual Exposure Since 1978 to a:				Reason:	
Hemophiliac		No	Yes	Medical/Social Services: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unk	
IV Drug User		<input checked="" type="radio"/>	<input type="radio"/>	Reason:	
Person With Known HIV Infection/AIDS		<input checked="" type="radio"/>	<input type="radio"/>	Partner Notification: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unk	
Man Who Has Sex With Men		<input checked="" type="radio"/>	<input type="radio"/>	Reason:	
Male Prostitute		<input checked="" type="radio"/>	<input type="radio"/>		
Female Prostitute		<input type="radio"/>	<input checked="" type="radio"/>		
Currently Pregnant: <input type="radio"/> Yes <input type="radio"/> No If Yes, Due Date					
Pregnant During Previous 5 Years: <input type="radio"/> Yes <input type="radio"/> No If Yes, Date of Last Delivery					

I have been informed about the HIV antibody test, the meaning of the possible results, the possible consequences of those results and that the information provided on this form is confidential. Having been so informed, I hereby voluntarily consent to be counseled and, or, tested for the HIV-ab. *Please see back of form.

Signature

Witness

Date

6143316947

PROVIDER COPY
Retain for your records

ADPH-CL-109 / REV 01-01

Bureau of Clinical Laboratories-Montgomery

PO BOX 244018, MONTGOMERY AL 36124-4018

Phone:(334) 260-3400 FAX:(334) 274-9800

Page: 1

Patient:

Sanford, Jeffery, Bernard**Provider:**TKD JUSTICE CENTER
PO BOX 2407
OPELIKA, AL, 36801-0000
(000) 000-0000,
UNKNOWN DOCTOR**Accession****4019569****ID:****1023986****Requisition #:****4019569****Service Area:****Collected: 3/30/2006 @****CHR #:****Received: 4/ 4/2006 @ 11:05 AM****Reported: 4/ 5/2006 @ 5:21 PM****D.O.B.:****Sex: M MALE****Phone: (000) 000-0000****SSN:****Status: Final Report**

Test Name	Result	Units	Normal Range	Notes
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Serology Results

VDRL, STS Qualitative

Non-Reactive

Lab Director**William J. Callan, Ph.D.**

Alabama Department of Public Health
TB Division
RSA Tower/201 Monroe Street
Montgomery, Alabama 36130-3017

TB

Skin Test Report

County Code 47Target Testing ☐PROJECT ☐CHR#

Last Name

Sanford, Jeffery Bernard

☐

MI

☐☒

B/M

City

☐

State

Zip Code

Home Phone

☐☐☐☐☐SSN: ☐☐☐

SEX:

☒ M ☐ F

Date of Birth:

☐☐☐

Race:

W B AI A AN H/PI O

☐ ☒ ☐ ☐ ☐ ☐ ☐

ETHNICITY:

Hispanic or Latino: ☐ YES ☐ NO

Test Administered By:

☐ TB Staff☐ PH Nurse☐ Other

Site Test:

☐ Health Department☒ Other

Reason Tested:

☐ Health Care Worker☐ Medical Risk☐ Shelter☐ Student☐ Occupational☐ Foreign Born☐ Homeless☒ Jail/Prison☐ Not at Risk

Contact to Case/Suspect:

☐ YES☒ NO

Risk Categories:

☐ A☒ B☐ C

PPD ONE:

Provider#: ☐Lot#: C8212A

Date of Test

03-23-2004

Antigen

☐ AP☒ TU

PPD TWO:

Provider#: ☐Lot#: ☐

Date of Test

☐

Antigen

☐ AP☐ TU

Provider#:

☐

Date Read

03-25-2006

Result

☒

mm

☐ Not Read

Provider#:

☐

Date Read

☐

Result

☐

mm

☐ Not Read

Race codes: W-White; B-Black; AI - American Indian; A-Asian; AN - Alaskan Native; H/PI-Hawaiian/Pacific Islander; O-Other

ADPH-TB - 26/REV-12-2002

Lee County Detention Center

INMATE REQUEST SLIP7-X
LOCATIONName Danzon, Jeffery Date 07/12/06☐ Telephone Call ☐ Doctor ☐ Dentist ☐ Time Sheet☐ Special Visit ☐ Personal Problem ☐ OtherBriefly Outline Your Request. Give To Jailer

Do Not Write Below This Line - For Reply Only

4/12/06 talked with Kristy
 in Oral Surgery & Jeff
 Eval. & apt. 3rd floor
 Start at 1700. 00 Dr. King
 said there is election
 nurse

Approved _____ Denied _____ Collect Call _____

All Request Will Be Routed Through The Sergeant Over The Jail, Then Forwarded To Those The Request is Directed.

☐ Lieutenant☐ Chief Deputy☐ Sheriff

Date _____ Time Received _____

CORRECTION OFFICER _____

FORM: LCS-038 (6/99)

LEE COUNTY SHERIFF'S DEPARTMENT RECORD OF MEDICAL EXAMINATION

(FORM #11)

PART 1: To be completed by Corrections Staff. (Please print clearly)

1. Inmate's name: Sandford, Jeffery
2. Date: 04/07/06
3. Time: 0745
4. Reason treatment was needed: I'm on Cephalexin 500mg 3ADay
Dental exam & Tx
5. Did Inmate request treatment? yes (If yes, place request form in Inmate's file if in writing)
6. Was inmate transported from the jail? yes
7. If yes, to what location? Dr. King's Office
8. Was inmate treated at the jail? yes
9. Who examined the inmate? Medical
10. Corrections Officer's name: _____ Signature: _____

PART 2: To be completed by person examining inmate. (Please print clearly)

1. Type of treatment/ examination: Exam, RA
2. Prognosis: Good w/ treatment
3. Is additional treatment needed? yes If so, please specify if other than medication:
Extraction Surg, wisdom teeth
4. Medication prescribed: Lorab 7.5 x 6, ~~Amox 500~~
5. Special instructions for administration: As prescribed
6. Other special instructions (restrictions of diet, activity, work, etc; observation orders; other):

WILLIAM G. KING, III, D.M.D.
227 E. MAGNOLIA AVENUE
AUBURN, AL 36830

Health Care Provider (Please print and give title, Re. M.D., R.N., D.D.S., etc.)

4/7/06
Date

8:07
Time

Will King
Signature

LEE COUNTY SHERIFF'S DEPARTMENT
SPECIAL REPORT.Subject: Sanford, Jeffrey Opelika, Ala., LCDC

To the Sheriff of Lee County:

I report the following Hoarding Lortab during free
Call which occurred at 0830 o'clockthis 4/8/06 M., at LCDC

Below give full-particulars, together with name of principals and witnesses and their address.

During free call with
Officer Sim I/m Sanford, Jeffrey
complaining about tooth pain. Informing
him He (Sanford) saw our Dentist
Dr. King Friday & have Lortab.
Gave I/m (Sanford) Meds
He (Sanford) continue talking when
ask open hand have Lortab free
between fingers. Informing I/m of
Section 10.4 inmate Rules &
Regulation Book.

Reported by Nurse Stewart GenAddress LEE COUNTY DETENTION CENTER Phone _____Complaint Received by NURSING How _____Assigned to PO BOX 2407
OPELIKA, AL 36803-2407

Lee County Detention Center
INMATE REQUEST SLIP

F-4
LOCATION

Name Jeff Sanford Date 4-2-06

☐ Telephone Call ☐ Doctor ☐ Dentist ☐ Time Sheet
☐ Special Visit ☐ Personal Problem ☒ Other Nurse

Briefly Outline Your Request. Give To Jailer

I really need some packs of
Triple Antibiotic Ointment to
heal a scar I have on my
leg. Thank you!

Do Not Write Below This Line - For Reply Only

4/4/06 Been on sick call today
[Signature]

Approved _____ Denied _____ Collect Call _____

All Request Will Be Routed Through The Sergeant Over The Jail, Then Forwarded To Those The Request is Directed.

☐ Lieutenant ☐ Chief Deputy ☐ Sheriff

Date _____ Time Received _____

CORRECTION OFFICER _____

Lee County Detention Center
INMATE REQUEST SLIP

F-4
LOCATION

Name Jeff Sanford Date 4-2-06

☐ Telephone Call ☐ Doctor ☐ Dentist ☐ Time Sheet
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Approved _____ Denied _____ Collect Call _____

All Request Will Be Routed Through The Sergeant Over The Jail, Then Forwarded To Those The Request is Directed.

☐ Lieutenant ☐ Chief Deputy ☐ Sheriff

Date _____ Time Received _____

CORRECTION OFFICER _____

PING FOR		THROUGH	
Physician <i>McFarland</i>		Telephone No.	Medical Record No.
Address		Alt. Telephone	
		Rehabilitative Potential	
Date of Birth <i>1/1/60</i> Sex <i>M</i> Race <i>C</i> Religion <i>C</i> Social Security Number <i>218-60</i>			
Paid Number	Medicare Number	Approved By Doctor: <i>Jeffery Sanford</i>	
		By: <i>CSA</i> Title: <i>CSA</i> Date: <i>2/1/60</i>	
DENT <i>Sanford, Jeffery</i>	D.O.B.	Sex	Room # <i>D-4</i>
		Patient Code	Admission Date

**NEWTON MEDICAL CENTER
5126 HOSPITAL DRIVE, NE
COVINGTON, GA 30014**

HEALTH INFORMATION MANAGEMENT

FAX (678) 625-2068
PHONE (770) 385-7817

FACSIMILIE TRANSMISSION COVERSHEET

C O N F I D E N T I A L

TO:

Lee Co. Sheriff's Dept.

FROM:

ROSEMERRY SIMMONS

HEALTH INFORMATION MANAGEMENT

DATE:

2-15-06

TOTAL NUMBER OF PAGES (INCLUDING COVERSHEET):

12

COMMENTS: Regarding -

Jeffery Senterford

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NEWTON GENERAL HOSPITAL

EMERGENCY PHYSICIAN RECORD

Abdominal Pain / Flank Pain (5)

TIME SEEN: 13:50 ROOM: 2 EMS Arrival

HISTORIAN: patient spouse paramedics

HX / EXAM LIMITED BY:

HPI

chief complaint:

abdominal pain
flank pain (R/L)vomiting
diarrhea

started:

Midnight / 12:00 AM

time course:

still present

better

gone now

lasted:

constant waxing / waning sudden-onset

intermittent episodes lasting

worse / persistent since

quality:

"pain"

aching

dull

burning

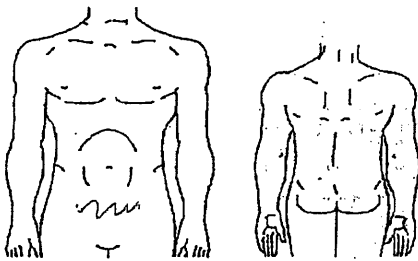
cramping

sharp

stabbing

fullness

location:



migration (show migration: m →)

associated with:

loss of appetite

nausea

vomiting

bloody blood-streaks coffee-grounds

diarrhea

blood streaks grassy bloody mucous

severity:

maximum (1-10)

mild moderate

severe

when seen in ED

(1-10)

none almost gone

mild moderate

severe

exacerbated by:

supine

upright pos.

movements / walking

cough / deep breaths

food

nothing

relieved by:

supine

upright pos.

remaining still

antacids

food

nothing

Similar symptoms previously: 1st 2nd 3rd

Gastroenteritis 2003

Recently seen / treated by doctor:

JEFFERY

WICKT, JOHN A MD

12/3/2005

Jeffery, John A MD

ROS 2/30/1965

GI

constipation

last BM: 1/2/06

black / bloody stools

GU

bloody / dark urine

frequent / painful urination

FEMALE REPRODUCTIVE

LNMP

vaginal discharge

abnormal bleeding

CONST

fever

chills

NEURO / EENT

headache

sore throat

blurred vision

CVS / PULMONARY

cough

trouble breathing

chest pain

MS / SKIN

skin rash

joint pain(s)

back pain

all systems neg. except as marked

PAST HX

negative

peptic ulcer

documented? yes no

gall stones

kidney stone(s)

bladder / kidney infection

heart disease

diabetes insulin / oral / diet

GERD

abdominal aneurysm

pancreatitis

diverticulitis

ovarian cyst(s)

pelvic infection

high cholesterol

high blood pressure

+HIV / AIDS

other problems: Colitis / IBS

Hypertension / Diabetes

Surgeries / Procedures

none / noncontributory

cholecystectomy

appendectomy

endoscopy

tonsillectomy

c-section

bilat tubal ligation

hysterectomy

cardiac bypass

Medications

none see nurses note

ASA

NSAID

acetaminophen

BCP's

Allergies

NKDA

see nurses note

SOCIAL HX

smoker

drugs

alcohol (recent / heavy / occasional)

FAMILY HX

gall stones

ovarian cysts

CAD

ulcer

kidney stones

C2001-2003 T-System, Inc. Circle or check affirmative, bracketed () negative.



NEWTON GENERAL HOSPITAL **EMERGENCY DEPARTMENT RECORD** **Physician Order Sheet**

LABS <input checked="" type="checkbox"/> Amyla <input type="checkbox"/> Basic Metabolic Panel <input type="checkbox"/> BNP (BN-PEP) <input checked="" type="checkbox"/> CBC <input type="checkbox"/> Chem / GC <input type="checkbox"/> CPK with MB / Elevated <input type="checkbox"/> Culture <input type="checkbox"/> GSTAN <input type="checkbox"/> GGT <input type="checkbox"/> Hepatic Function <input type="checkbox"/> Inhouse Drug screen <input checked="" type="checkbox"/> Lipase <input type="checkbox"/> Magnesium <input type="checkbox"/> Preg qual. <input type="checkbox"/> Preg quant. <input type="checkbox"/> PTT / PT <input type="checkbox"/> TSH <input type="checkbox"/> Typonin <input type="checkbox"/> UA <input type="checkbox"/> Wet PR <input type="checkbox"/> Skull <input type="checkbox"/> Spn / G <input type="checkbox"/> Spn / T <input type="checkbox"/> Spn / LS <input type="checkbox"/> CRF <input type="checkbox"/> Riba <input type="checkbox"/> KUB <input checked="" type="checkbox"/> ABD <input type="checkbox"/> Shoulder R L <input type="checkbox"/> Scapular R L <input type="checkbox"/> Humerus R L <input type="checkbox"/> Elbow R L <input type="checkbox"/> F Arm R L <input type="checkbox"/> Wrist R L <input type="checkbox"/> Hand R L <input type="checkbox"/> Pelvis R L <input type="checkbox"/> Hip R L <input type="checkbox"/> Femur R L <input type="checkbox"/> Knee R L <input type="checkbox"/> Tib Fib R L <input type="checkbox"/> Ankle R L <input type="checkbox"/> Foot R L		STANDARD PANELS + CSF pk Glucose Total Protein Cell count diff CSF culture + Vag pk Chlamydia GC Gon Stain Wet Prep + Cardiac pk EKG PCCP CBC CPK BMP Troponin Mg + Psych Inhouse drug screen urine drug screen CBC BMP GT Sinus C S Head C S Chest C S abd CPO CIV S pelvis CPO CIV S US <input type="checkbox"/> U/S ABD <input type="checkbox"/> U/S Pelvis <input type="checkbox"/> U/S Testes / Adrena <input type="checkbox"/> U/S Legs R L CARDIORESPIRATORY + EKG + aerosol with + ABG RA / O2 + Culture urine blood stool + Stool leukocytes + Stool hemocult
---	--	--

Discharge Instructions

1. Fk DR. Malincon
 2. DR. Malincon 12/12
 3. DR. Malincon 12/12
 4. DR. Malincon 12/12

V0201240000

000154665

FORD, JEFFERY

WICKY, JOHN A MD

12/23/2005

12/30/1995

SELF

Initial Nursing Orders

<input type="checkbox"/> Cardiac Monitor	Noted
<input type="checkbox"/> Pulse Oximeter	
<input type="checkbox"/> Oxygen LNC	
<input type="checkbox"/> Sinks to keep sat greater than 86%	
<input type="checkbox"/> Fully Dressed / Gown	
<input type="checkbox"/> Orthostatic Vitals	
laying	
sitting	
standing	
<input type="checkbox"/> Neuro checks q	
<input type="checkbox"/> IV INT	ml / hr

Subsequent Nursing Orders

Time	Order	Noted
	<input type="checkbox"/> Please repeat: BP HR RR Temp	
	<input type="checkbox"/> May be off cardiac monitor for radiology studies or transport.	
	<input type="checkbox"/> Obtain Medical Record	

1. DR. Malincon 12/24/05
 2. DR. Malincon 12/24/05
 3. DR. Malincon 12/24/05
 4. DR. Malincon 12/24/05

DISPOSITION

<input type="checkbox"/> ADMIT	<input type="checkbox"/> OBS	<input type="checkbox"/> DISCHARGE
med / surg	intensity	L & D
Dr.		
Condition:	<input type="checkbox"/> critical	<input type="checkbox"/> improved
	<input type="checkbox"/> stable	<input type="checkbox"/> other
<input type="checkbox"/> TRANSFER to:		Care of Dr.

Dr.
 called
 answered

OFFICER SIGNATURE

MENTAL HEALTH

PHYSICIAN SIGNATURES / PA SIGNATURES

1. DR. Malincon 12/24/05

NEWTON MEDICAL CENTER

EMERGENCY DEPARTMENT NURSING RECORD

ACUITY CODE I II III (Circle One)

VOC0012408431

010184685

FORD, JEFFERY

DATE 4-23-05 NAME Jeffery Ford AGE 37 DOB 12-20-68

ARRIVED BY: ☐ Walked ☐ Carried ☐ W/C ☐ EMS ☒ Pain Scale 4 /10 H/C 3 CM, WT 175 FLB

VITALS: Sitting B/P 114/79 P 81 R 18 T 98.5 (O R A) SpO₂ 100 Standing B/P 114/79 P 81

C/O: Went to ER after feeling dizzy & lightheaded

ALLERGIES: ☐ NKA ☐ Latex ☐ Iodine/Contrast ☒ PCN ☐ Sulfa ☐ Codeine

HISTORY: ☐ Kidney ☐ Hypertension ☐ Cardiac ☐ Cancer ☐ Lung ☒ Diabetes ☐ Neuro ☐ Other: 3rd degree heart block

☐ No significant history ☐ Surgery

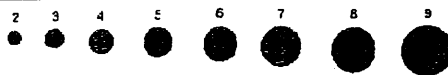
MEDICATIONS:

☐ None☐ See list

Last Menstrual Period: 12/20/04 G: 1 P: 1 M: 1 A: 1

TETANUS: ☐ Unknown ☐ <5 years ☐ >5 years

IMMUNIZATIONS: Up to date ☐ Yes ☐ No ☐ Unknown ☐ Newborn



Pupil Size: R 4 mm L 4 mm

Pupil Reaction: R 4 mm L 4 mm

Visual Acuity: 20/20 Both

Right Eye 20/20 Left Eye 20/20

GCS:

☐ Brisk☐ Sluggish☐ Equal/round☐ NonreactiveINTEGUMENTARY: ☐ WNL☐ Cool ☐ Hot ☐ Pale☐ Diaphoretic ☐ Cyanotic

TB SCREENING: ☐ Unable to assess

Have you had a cough for more than 3 weeks: ☐ Yes ☒ No

If yes, have you been exposed to TB? ☐ Yes ☐ No

If yes, have you had a TB test? ☐ Yes ☐ No Results: +/-

Significant weight loss: ☐ Yes ☐ No; Fever: ☐ Yes ☐ No

Hemoptysis: ☐ Yes ☐ No; Night Sweats: ☐ Yes ☐ No

TREATMENT PRIOR TO ADMISSION:

IV: 100 ASA: 1 NTG: 0 O₂: 2L

HR: 60 R: 18 B/P: 114/79 SpO₂: 100

BG: 100 ☐ Back Board ☐ C-Collar ☐ Splinting

Other: None

NEEDS ASSESSMENT: ☐ None noted

Communication: ☐ Language barrier ☐ Other: None

Primary Language: English

Interpreter: ☐ Family ☐ Friend ☐ Other: None

Psychosocial: ☐ Assist with ADL

Hearing: ☐ Impaired ☐ Other: None

Vision: ☐ Impaired ☐ Other: None

Religious Needs: None

TRIAGE NURSE:

TIME: 1:55PMD: None

AIRWAY: ☒ Clear ☐ Obstructed ☐ Artificial

BREATHING:

☒ Unlabored ☐ Labored

☐ Retractions ☐ Stridor ☐ Assisted

Breath Sounds: Clear

L R 35/40

☒ Clear

☐ Coarse

☐ Crackles

☐ Wheezes

☐ Diminished

☐ Absent

CIRCULATION: ☐ WNL

Radial: 0 1 2 3 Carotid: 0 1 2 3

Heart Tone: ☐ Clear ☐ Muffled

☐ Jugular Vein Distention

Edema: ☒ N/A ☐ L ☐ R ankles / legs

Other: None

Capillary refill: time 3 sec

NEURO:

☐ Alert and Oriented x 4

☐ Awake, confused ☐ Unresponsive

☐ Grip Strength: (use <, >, =) R 4 L 4

Speech: ☐ Clear ☐ Slurred

Facial Droop: L R None

HEAD: ☐ WNL

HA None

Description: None

Location: None

EYE: ☐ WNL

☐ Sclera None

☐ Drainage None

☐ Blurred Vision None

EAR: ☐ WNL

☐ Drainage None

☐ Other None

NOSE: ☐ WNL ☐ Injury

☐ Bleeding/Drainage None

☐ Other None

NECK/THROAT: ☐ WNL

Nuchal Rigidity ☐ Yes ☐ No

CHEST: ☐ WNL

Contusions None

Abrasions None

Lacerations None

Deformity None

Radiation: None

Other: None

Cough: ☐ Productive ☐ Non-productive

MUSCULOSKELETAL: ☐ WNL

Upper Extremities R L

Contusion None

Abrasion None

Laceration None

Swelling None

Deformity None

Other: None

Lower Extremities R L

Contusion None

Abrasion None

Laceration None

Swelling None

Deformity None

Other: None

Pelvis: ☐ Stable ☐ Unstable

Back None

Contusion None

Abrasion None

Laceration None

Swelling None

Deformity None

Other: None

ABDOMEN: ☐ WNL

Bowel sounds:

☐ Decreased

☐ Increased

☐ Absent

☐ Soft ☐ Firm

☐ Rigid ☐ Distended ☐ Tender

☐ Nausea ☐ Vomiting ☐ Diarrhea

Other: None

GU/GYN: ☐ WNL

☐ Frequency ☐ Urgency ☐ Burning

☐ Hematuria ☐ Unable

Discharge/bleeding: ☐ Yes ☐ No ☐ Odor

Pregnant: ☐ Yes ☐ No

EDC: None FHT: None bpm

Location: None

PEDIATRIC:

☐ Consolable ☐ Playful ☐ Alert

☐ No eye contact ☐ Inconsolable

Fontanelles: ☐ Full ☐ Bulging ☐ Depressed

☐ Flaccid muscle tone

Mucous membranes: ☐ Moist ☐ Dry

PSYCHIATRIC: ☐ Appropriate

☐ Cooperative ☐ Depressed

☐ Agitated ☐ Combative

☐ Drug /ETOH abuse

Other: None

VALUABLES: ☐ Yes ☐ No ☐ With Patient Given to: None

PRIMARY NURSE: [Signature]

TIME: 1:30

NMC2001886
REV. 12/29/04

PHYSICAL EXAM**General Appearance**

☒ no acute distress ☐ mild / moderate / severe distress
☒ alert ☐ anxious / lethargic
☐ IV

EENT

☒ eyes inspection nml ☐ scleral icterus / pale conjunctivae
☒ ENT inspection nml ☐ pharyngeal erythema
☐ pharynx nml ☐ abnml TM / hearing deficit

NECK

☒ nml inspection ☐ thyromegaly
☐ lymphadenopathy (R / L)

RESPIRATORY

☒ no resp. distress ☐ wheezing
☒ breath sounds nml ☐ rales / rhonchi

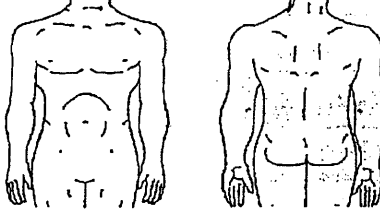
CVS

☒ regular rate, rhythm ☐ irregularly irregular rhythm
☒ heart sounds normal ☐ tachycardia / bradycardia

☐ JVD present
☐ gallop (S3 / S4)
☐ murmur grade ___ / 6 sys / dias
☐ decreased pulse(s)

R carotd ___ fem ___ dors ped ___
 L carotd ___ fem ___ dors ped ___

T = tenderness
 G = guarding
 R = rebound
 m = mild
 mod = moderate
 sv = severe
 Example:
 Tsv = sev. tenderness

**ABDOMEN**

☒ soft ☐ distention
☐ non-tender ☐ tenderness *lower abd*
☒ no organomegaly ☐ guarding / rebound
☒ nml bowel sounds ☐ hepatomegaly / splenomegaly / mass
☐ no pulsatile mass ☐ abnormal bowel sounds
☐ increased / decreased / absent / tympanic
☐ prominent aortic pulsations

PELVIC EXAM

☐ external exam nml ☐ vaginal bleeding / discharge
☐ speculum exam nml ☐ cervical motion tenderness
☐ bimanual exam nml ☐ adnexal tenderness (R / L)
☐ enlarged / tender uterus
☐ adnexal mass (R / L)

MALE GENITAL

☐ normal inspection ☐ tenderness / swelling testicular / inguinal

RECTAL

☐ non-tender ☐ black / bloody / heme pos. stool
☐ heme neg stool ☐ tenderness

BACK

☒ normal inspection ☐ CVA tenderness (R / L)

SKIN

☒ color nml, no rash ☐ cyanosis / diaphoresis / pallor
☐ warm, dry ☐ skin rash

EXTREMITIES

☒ non-tender ☐ pedal edema
☒ normal ROM ☐ calf tenderness
☐ no pedal edema

NEURO / PSYCH

☒ oriented x3 ☐ disoriented to person / place / time
☐ mood / affect nml ☐ depressed affect
☐ CN's nml as tested ☐ facial droop / EOM palsy / anisocoria
☐ no motor / sensory deficit ☐ weakness / sensory loss

Abdominal Pain - 36

LABS, EKG & XRAYs

CBC	Chemistries	Lipase	UA
normal except	normal except	277	normal except
WBC 6.1	Na 143	Amylase 75	WBC
Hgb 13.2	K 3.4	Alk Phos	RBC's
Hct 38.4	Cl 103	SGPT	bacteria
Platelets 221	CO2 29	Quant.	dip
segs 45	Gluc 81	BHCG / Qual.	
bands	BUN 14	serum / urine	
lymphs 39	Creat 1.0	preg	
monos	Ca 9.4	POS NEG	

EKG MONITOR STRIP ☐ NSR ☐ Rate

EKG ☒ NML ☐ Read by me ☐ Read by Dr.

☐ NSR ☐ nml intervals ☐ nml axis ☐ nml QRS ☐ nml ST/T

☐ not / changed from

XRAYs ☐ Read by me ☐ Read by Dr.

☒ KUB ☐ Upright abd ☒ 3-view ☐ CXR pa lat ap

☐ nml / NAD ☐ nml bowel gas ☐ no free air ☐ no mass

☐ no infiltrates ☐ nml heart size ☐ nml mediastinum

☐ not / changed from *QAA 9/25/06 WND*

IVP ☐ CT

Ultrasound ☐ nml ☐ GB stones / pericolic fluid / thick GB wall

☐ dilated common duct ☐ abnml pancreas / aorta / pelvic / appendix

Pulse Ox ___ % on RA / ___ L / ___ % at (time)

PROGRESS:

Time ___ unchanged improved re-examined

Discussed with Dr. ___ Time ___

will see patient in: office / ED / hospital

Counseled patient / family regarding: ☐ CRIT CARE- 30-74 min

lab results: diagnosis need for follow-up 75-104 min ___ min

Admit orders written Additional history from:

Prior records ordered family caretaker paramedics

CLINICAL IMPRESSION:

Abdominal Pain - acute Appendicitis - acute

Vomiting Aortic Aneurysm - ruptured

Ureterolithiasis / Renal Colic R / L M.I. / Angina / Mesenteric Ischemia

U.T.I. / Pyelonephritis - acute Bowel Perforation / Obstruction

Gastroenteritis / Gastritis acute Pancreatitis - acute

Peptic Ulcer Disease Cholecystitis-w/cholelithiasis / acalculous

Pelvic Inflammatory Disease Biliary Colic

Ovarian Cyst ruptured torsed Diverticulitis - acute

GERD

___, the Physician, have evaluated the patient and the work-up and agree with the PA's documentation.

Google

[illegible]

Certification and Number

NEWTON GENERAL HOSPITAL
COVINGTON, GEORGIA

PT NAME: SANFORD,JEFFERY
ROOM-BED:
AGE: 39

SEX: M

MR NUMBER: M000184685
PT NUMBER: V00012408431
DOB: [REDACTED]

PT Status: DEP ER

JOB # 350898

XRAY # 143391

ACUTE ABDOMEN SERIES: 04/23/05

INDICATION: Abdominal pain and blood in stool.

CHEST:

A single frontal view of chest was obtained.

The cardiovascular structures, lungs and thoracic skeleton are unremarkable for age.

IMPRESSION:

NORMAL CHEST FILMS.

ABDOMEN:

Upright and supine views of abdomen show air-filled loops of small and large bowel without distention. An occasional air-fluid level is present. No free air is noted in the peritoneum. The psoas outlines are obscured. No mass is identified. Several calcifications in the pelvis are probably representing phleboliths. Bones are normal.

IMPRESSION:

A NONSPECIFIC BOWEL GAS PATTERN.

<Electronically signed by ALMASS N WELJI MD>

WELJI, ALMASS N MD

WELAL/MBAILEY
D:04/24/05
T:04/27/05
0427-0030

RADIOLOGY REPORT

Medical Records
Medical Records' copy

RUN DATE: 04/23/05
 RUN TIME: 1442

Newton General Hospital
 5126 Hospital Drive
 Covington, Georgia 30014
 Jo Marie Lyons, MD, Laboratory Director

PAGE 1

Name: SANFORD, JEFFERY Age/Sex: 39/M Attend Dr: KROWICKI, JOHN A MD
 Acct#: V00012408431 Unit#: M000184685 Status: REG ER Location: ER
 Reg: 04/23/05 Disch: DOB: [REDACTED] 5

Specimen: 0423:H00059S Collected: 04/23/05-1414 Status: COMP Req#: 00229598
 Received: 04/23/05-1414 Subm Dr: KROWICKI, JOHN A MD

FAX TO:

Ordered: CBC

Comments: Comments to Phlebotomist: ER FT 2

Test	Result	Flag	Reference
COMPLETE BLOOD COUNT			
> WHITE BLOOD COUNT	6.1		4.5-11.0 K/mm3
> RBC	4.10	L	4.60-6.20 M/mm3
> HEMOGLOBIN	13.2	L	13.5-17.5 g/dL
> HEMATOCRIT	38.4	L	41.0-53.0 %
> MCV	93.6		80.0-100.0 fL
> MCH	32.2	H	27.0-31.0 pg
> MCHC	34.4		31.0-37.0 g/dL
> RDW	14.1		11.5-14.5 %
> PLATELET COUNT	221.0		150.0-350.0 K/mm3
> MPV	7.6		fL
> AUTO NEUT	45.4		40-70 %
> AUTO LYMPH	39.5		22-44 %
> AUTO MONO	11.5	H	2-8 %
> AUTO EOS	3.0		1-5 %
> AUTO BASO	0.6		0-3 %
> NRBC %	0.0		0.0-1.00

** END OF REPORT **

RUN DATE: 04/23/05
 RUN TIME: 1459

Newton General Hospital
 5126 Hospital Drive
 Covington, Georgia 30014
 Jo Marie Lyons, MD, Laboratory Director

PAGE 1

Name: SANFORD, JEFFERY Age/Sex: 39/M Attend Dr: KROWICKI, JOHN A MD
 Acct#: V00012408431 Unit#: M000184685 Status: REG ER Location: ER
 Reg: 04/23/05 Disch: DOB: [REDACTED]

Specimen: 0423:C00070S Collected: 04/23/05-1414 Status: COMP Req#: 00229598
 Received: 04/23/05-1414 Subm Dr: KROWICKI, JOHN A MD

FAX TO:

Ordered: BMP, AMYLASE, LIP

Comments: Comments to Phlebotomist: ER FT 2

Test	Result	Flag	Reference
BASIC METABOLIC PANEL			
> SODIUM LEVEL	143		135-146 MMOL/L
> POTASSIUM LEVEL	3.4	L	3.5-5.0 MMOL/L
> CHLORIDE LEVEL	108	H	98-107 MMOL/L
> CARBON DIOXIDE	29		22-31 MMOL/L
> GLUCOSE	81		75-110 mg/dL
> BUN	14		9-21 mg/mL
> CREAT SERUM	1.0		0.8-1.5 mg/dL
> CALCIUM LEVEL	9.4		8.4-10.1 mg/dL
> AMYLASE LEVEL	75		30-110 U/L
> LIPASE	271		114-286 U/L

** END OF REPORT **

RUN DATE: 04/24/05
 RUN TIME: 0032

Newton General Hospital
 5126 Hospital Drive
 Covington, Georgia 30014
 Jo Marie Lyons, MD, Laboratory Director

PAGE 47

SPEC # 0423.H00059S PATIENT: SANFORD, JEFFERY #V00012408431 (Continued)

Test	Result	Flag	Reference
> MCV	93.6		80.0-100.0 fL
> MCH	32.2	H	27.0-31.0 pg
> MCHC	34.4		31.0-37.0 g/dL
> RDW	14.1		11.5-14.5 %
> PLATELET COUNT	221.0		150.0-350.0 K/mm3
> MPV	7.6		fL
> AUTO NEUT	45.4		40-70 %
> AUTO LYMPH	39.5		22-44 %
> AUTO MONO	11.5	H	2-8 %
> AUTO EOS	3.0		1-5 %
> AUTO BASO	0.6		0-3 %
> NRBC %	0.0		0.0-1.00

** CONTINUED ON NEXT PAGE **

RUN DATE: 04/23/05
RUN TIME: 1532

Newton General Hospital
5126 Hospital Drive
Covington, Georgia 30014
Jo Marie Lyons, MD, Laboratory Director

PAGE 1

Name: SANFORD,JEFFERY Age/Sex: 39/M Attend Dr: KROWICKI,JOHN A MD
Acct#: V00012408431 Unit#: M000184685 Status: REG ER Location: ER
Reg: 04/23/05 Disch: DOB: [REDACTED]

Specimen: 0423:CM000108 Collected: 04/23/05-1414 Status: COMP Req#: 00229598
Received: 04/23/05-1414 Subm Dr: KROWICKI,JOHN A MD

FAX TO:

Ordered: BNPEP

Comments: Comments to Phlebotomist: ER FT 2

Test	Result	Flag	Reference
B-NATRIURETIC PEPTIDE ASSAY			
> B-NATRIURETIC PEPTIDE ASSAY	6.1		0-100
> BNP INTERNAL QC	OK		

** END OF REPORT **

**SHERIFF OF LEE COUNTY****JAY JONES**

P.O. BOX 2407
OPELIKA, AL 36803-2407
PHONE (334) 737-3582
FAX (334) 737-3574
E-MAIL: LCSO@MINDSPRING.COM

FACSIMILE COVER SHEETDATE: 2/15/06ATTN: Medical Records Newton Medical CenterFROM: Nursing Dept ext 3590

MESSAGE: _____

NUMBER OF PAGES INCLUDING COVER SHEET 2

(678) 625-2068

faxed
2/15/06
JD

(check all that apply):

() use the following health information maintained by Lee County Sheriff's Office.

☒ disclose the following health information to:
LEE COUNTY SHERIFF
2311 GATEWAY DRIVE
OPELIKA, AL 36803

☒ obtain the following health information from:

EAMC
New Lee County Hosp & H
D. H. H.

Specific description of the health information to be used/disclosed/obtained (include dates of service, type of service, etc): any & all information about
Abil pain

This health information is used/disclosed/obtained for the purpose (if Authorization requested by the patient put: "At the request of the individual"): Conf. To D M = Farland

I understand that this health information may include information regarding drugs and alcohol, human immunodeficiency virus test results, and psychotherapy notes.

If the disclosure is for marketing purposes, will the Lee County Sheriff's Office directly or indirectly receive remuneration for the disclosure of health information? Yes ___ No ___ N/A ___.

By providing this Authorization, I understand as follows:

I understand that this Authorization is voluntary. I may refuse to sign this Authorization and my treatment and/or payment obligations will not be affected.

1. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and my treatment and/or payment obligations will not be affected.
2. I understand that the health information to be released may be subject to re-disclosure by the recipient of the health information and no longer protected by the Federal Privacy Rules.
3. I understand that I may revoke this Authorization at any time by notifying the Lee County Sheriff's Office in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.
4. I understand that I will receive a copy of this Authorization form after I sign it.
5. I understand that this Authorization will expire on 2 / 6 / 07 (MM/DD/YR) or upon the following event (if for research put "None" or "End of the research study"): _____ If an expiration date is not chosen, this authorization will cease to be valid 90 days from the date of signature.

Jeffery B. Sanford, Jr.
 Signature of Patient or Patient Representative

Feb 7, 06
 Date

Printed Name of Patient's Representative (if applicable)

Representative's Relationship to Patient (if applicable)

LEE COUNTY SHERIFF'S OFFICE

PATIENT INFORMATION

PATIENT AUTHORIZATION FOR USE
 AND/OR DISCLOSURE OF PROTECTED
 HEALTH INFORMATION

PATIENT NAME: Samuel, Jeffrey

SOCIAL SECURITY NO. 31-111111111

DATE OF BIRTH 1/1/1985



MEDICAL INFORMATION TRANSFER FORM

Confidential Medical Data

KILBY CORRECTIONAL FACILITY

(Agency)

P.O. BOX 125

(Address)

MT. MEIGS, AL 36057-0125

LEE COUNTY DETENTION CENTER

(Institution)

P.O. BOX 688

(Address)

OPELIKA, AL 36801 (334-749-5651)

(Telephone)

Inmate's Name: Sanford, Jeffery Bernard

a/k/a: _____

D.O.B.: _____

ID# _____

Person Completing Form _____

Print Name: D. Burke Lynn

Signature: D. Burke Lynn

Date: 08/12/03

MEDICAL PROBLEMS

None

TREATMENTS/MEDICATIONS

None

Test:

Write:

Yes

No

Unknown

Lab Data:

TB Skin Test:

NEG

POS

Date: _____

CXR:

NEG

POS

Date: _____

Test:

RPR:

NEG

POS

Treated

Yes No

Date: _____

VDRL:

NEG

POS

Yes No

GC:

NEG

POS

Yes No

Other:

Yes No

Receiving Institution —

Medical File —



SHERIFF OF LEE COUNTY
JAY JONES



E-mail:
lcsso@mindspring.com

P.O. BOX 688
OPELIKA, AL 36803-0688

Phone (334) 749-5651
Fax (334) 749-4835

ATTENTION NURSING

I Jeffery Sanford HEREBY GIVE MY
CONSENT FOR E.A.M.C.
TO RELEASE ANY AND ALL MEDICAL INFORMATION PERTINENT
TO MY MEDICAL HISTORY TO LEE COUNTY SHERIFF DEPART-
MENT.

[REDACTED]
SS#

[Signature]
PATIENT/INMATE SIGNATURE

[REDACTED]
DOB

7-19-03
DATE

ADDRESS: LEE COUNTY SHERIFF DEPARTMENT
JAY JONES, SHERIFF
POST OFFICE BOX 688
OPELIKA, AL. 36804

03/28/2006 10:14:37

LEE COUNTY SHERIFF'S OFFICE
INMATE BOOKING SHEET

PAGE 1

BOOKING NO: 060001328

INMATE NAME: SANFORD JEFFERY BERNARD

ALIAS:

ALIAS:

ADDRESS: [REDACTED]

CITY/ST/ZIP: OPELIKA, AL 36801

HOME PHONE: [REDACTED]

DOB: [REDACTED] AGE: 40

PLCE BIRTH: INDIANAPOLLIS

STATE: IN

M. STATUS:

RELIGION: CHRISTIAN

GANG ASSOC: NONE

SCARS/TATTOOS: NONE

KNOWN ENEMIES: NONE

REMARKS: NONE

RACE: B SEX: M

HT: 6'01" HAIR: BLK

WT: 255 EYES: BRO

COMPLEX:

SSN: [REDACTED]

DL ST: AL DLN: [REDACTED]

SID:

LOCID: 3823

----- NEXT OF KIN -----

NEXT OF KIN: JOAN FOREMAN

ADDRESS: SAA

CITY/ST/ZIP: ,

REMARKS:

RELATIONSHIP: FRIEND

PHONE: 000-864-0973

----- EMPLOYER INFO -----

EMPLOYED: N

EMPLOYER NAME: SOUTHERN UNION

ADDRESS:

CITY/ST/ZIP: OPELIKA, AL 36801

PHONE: 334-745-0325

----- MEDICAL -----

HANDICAPPED: Y NEEDS:

GLASSES: N SMOKE: N

MEDICAL NEEDS: N NEEDS: N

PHYSICIAN:

PHONE: 000-000-0000

REMARKS: FRACTURED WRIST,

REMARKS: ALLERGEIC TO PENNCILLIN, WASP STINGS, BEE STINGS

REMARKS:

----- PROPERTY -----

CASH: \$00.00

DESCRIPTION:

DD. PROPERTY: STREET CLOTHES, LIGHTER, KEYS, BELT, (SILVER WATCH)

DD. PROPERTY:

DD. PROPERTY:

BIN NUMBER: 311

EH IMPOUNDED:

IMPOUND LOT:

REMARKS:

REMARKS:

=====

HAVE READ THE ABOVE ACCOUNTING OF MY PERSONAL INFORMATION, MEDICAL
NFORMATION, MONEY, AND OTHER PROPERTY AND I FIND IT TO BE TRUE AND ACCURATE.

INMATE: _____ DATE: _____ TIME: _____

BOOK OFFICER: _____ DATE: _____ TIME: _____

03/28/2006 10:14:37 LEE COUNTY SHERIFF'S OFFICE
INMATE BOOKING SHEET PAGE 2

BOOKING NO: 060001328 INMATE NAME: SANFORD JEFFERY BERNARD

COURT: CIRCUIT ATTORNEY ON REC:
JUDGE: DENSON PHONE: 000-000-0000
REMARKS:
REMARKS:

BOOK DATE: 03/13/2006 BOOK TIME: 07:23 BOOK TYPE: NORMAL

ARREST DATE: 03/13/2006 BOOKING OFFICER: DOWDELL S
ARREST DEPT: LCSO CELL ASSIGNMENT: F4
ARRST OFFICER: MARTINEZ MEAL CODE: 01 LEE COUNTY
PROJ. RLSDATE: 00/00/0000 FACILITY: 01 COUNTY JAIL
SEARCH OFFCR: CPL.COWHICK CLASSIFICATION:
TYPE SEARCH: DRESSED OUT WORK RELEASE: N
INTOX RESULTS: SOBER

HOLDS: N
AGENCY: REASON:
AGENCY: REASON:
AGENCY: REASON:
AGENCY: REASON:

NOTES:
NOTES:
NOTES:

LEE COUNTY SHERIFF'S OFFICE
INMATE CHARGE SHEET

03/28/2006 10:14:37

PAGE 3

BOOKING NO: 060001328

INMATE NAME: SANFORD JEFFERY BERNARD

CHARGE NO: 1 DISPOSITION: DROPPED

HOLD: N

ALA STATUTE:

OF COUNTS: 0

OFFENSE:

WARRANT #:

CASE #: CC2006-000037.00

BOND AMT: 0

FINE: \$0.00

BAIL AMT: 0

INIT APPEAR: 00/00/0000

SENTENCE DATE: 00/00/0000

RELEASE DTE: 00/00/0000

ARREST DATE: 03/13/2006

ARST AGENCY: LCSO

ARST OFFICR: MARTINEZ

COUNTY: LEE

COURT: CIRCUIT

JUDGE: DENSON

DEF ATTORNY:

DIST ATTORNEY:

COMMENTS:

COMMENTS:

COMMENTS:

CHARGE NO: 2 DISPOSITION: OPEN

HOLD: N

ALA STATUTE: CC06-37

OF COUNTS: 0

OFFENSE: THEFT II

WARRANT #:

CASE #: CC06-37

BOND AMT: 3000

FINE: \$0.00

BAIL AMT:

INIT APPEAR: 00/00/0000

SENTENCE DATE: 00/00/0000

RELEASE DTE: 00/00/0000

ARREST DATE: 03/14/2006

ARST AGENCY: BAD BOYZ

ARST OFFICR: CORY MARADUKE

COUNTY: LEE

COURT:

JUDGE: DENSON

DEF ATTORNY:

DIST ATTORNEY:

COMMENTS:

COMMENTS:

COMMENTS:

LEE COUNTY SHERIFF'S OFFICE
INMATE BOOKING SHEET

PAGE 1

02/01/2006 10:38:42

BOOKING NO: 060000564

INMATE NAME: SANFORD JEFFERY BERNARD

ALIAS:

ALIAS:

ADDRESS: [REDACTED]

CITY/ST/ZIP: OPELIKA, AL 36801

HOME PHONE: [REDACTED]

DOB: [REDACTED] AGE: 40

PLCE BIRTH: INDIANAPOLLIS

STATE: IN

M. STATUS: SINGLE

RELIGION: CHRISTIAN

GANG ASSOC: NONE

SCARS/TATTOOS: NONE

KNOWN ENEMIES: NONE

REMARKS: NONE

RACE: B SEX: M

HT: 6'01" HAIR: BLK

WT: 255 EYES: BRO

COMPLEX:

SSN: [REDACTED]

DL ST: AL DLN: [REDACTED]

SID:

LOCID: 3823

----- NEXT OF KIN -----

NEXT OF KIN: JOAN FOREMAN

ADDRESS: SAA

CITY/ST/ZIP: ,

REMARKS:

RELATIONSHIP: FRIEND

PHONE: 000-864-0973

----- EMPLOYER INFO -----

EMPLOYED: N

EMPLOYER NAME: SOUTHERN UNION

ADDRESS:

CITY/ST/ZIP: OPELIKA, AL 36801

PHONE: 334-745-0325

----- MEDICAL -----

HANDICAPPED: Y NEEDS:

GLASSES: N SMOKE: N

MEDICAL NEEDS: N NEEDS: N

PHYSICIAN:

PHONE: 000-000-0000

REMARKS: FRACTURED WRIST,

REMARKS: ALLERGEIC TO PENNCILLIN, WASP STINGS, BEE STINGS

REMARKS:

----- PROPERTY -----

CASH: \$00.00

DESCRIPTION:

ADD. PROPERTY: WALLET, BELT, HAT, JACKET, DU RAG,

ADD. PROPERTY:

ADD. PROPERTY:

BIN NUMBER: 193

VEH IMPOUNDED:

IMPOUND LOT:

REMARKS:

REMARKS:

I HAVE READ THE ABOVE ACCOUNTING OF MY PERSONAL INFORMATION, MEDICAL INFORMATION, MONEY, AND OTHER PROPERTY AND I FIND IT TO BE TRUE AND ACCURATE.

INMATE: [Signature]

DATE: TIME:

BOOK OFFICER: [Signature]

DATE: 2-1-06 TIME: 1040

LEE COUNTY SHERIFF'S OFFICE
MEDICAL SCREENING FORM

PAGE 1

02/01/2006 10:38:42

Booking No: 060000564 Date: 02/01/2006 Time: 10:29 Type: NORMAL
 Agency to Bill: LEE COUNTY Facility: COUNTY JAIL

Inmate Name: SANFORD JEFFERY BERNARD Race: B Sex: M
 DOB: 12/27/1965 Age: 40 SSN: [REDACTED] Height: 6'01" Weight: 255

- N 1. Is inmate unconscious?
- N 2. Does inmate have any visible signs of trauma, illness, obvious pain and bleeding, requiring immediate emergency or doctor's care?
- N 3. Is there obvious fever, swollen lymph nodes, jaundice or other evidence of infection that might spread through the facility?
- N 4. Any signs of poor skin condition, vermin, rashes or needle marks?
- N 5. Does inmate appear to be under the influence of drugs or alcohol?
- N 6. Any visible signs of alcohol or drug withdrawal?
- N 7. Does inmate's behavior suggest the risk of suicide or assault?
- N 8. Is inmate carrying any medication?
- N 9. Does the inmate have any physical deformities?
- N 10. Does inmate appear to have psychiatric problems?
11. Do you have or have you ever had or has anyone in your family ever had any of the following?
- | | | |
|-------------------------|-----------------------------------|------------------------------|
| <u>yes</u> a. Allergies | <u>N</u> f. Fainting Spells | <u>N</u> k. Seizures |
| <u>yes</u> b. Arthritis | <u>N</u> g. Hearing Condition | <u>N</u> l. Tuberculosis |
| <u>N</u> c. Asthma | <u>N</u> h. Hepatitis | <u>yes</u> m. Ulcers |
| <u>yes</u> d. Diabetes | <u>yes</u> i. High Blood Pressure | <u>N</u> n. Venereal Disease |
| <u>N</u> e. Epilepsy | <u>N</u> j. Psychiatric Disorder | <u>N</u> o. Other (Specify) |

Other: _____

12. For females only:

- N a. Are you pregnant?
- N b. Do you take birth control pills?

LEE COUNTY SHERIFF'S OFFICE

07/18/2003 14:15:28

INMATE BOOKING SHEET

PAGE 1

BOOKING NO: 030003117

INMATE NAME: SANFORD JEFFERY BERNARD

ALIAS:

ALIAS:

ADDRESS: 212 ROBBEN ST #100

CITY/ST/ZIP: OPELIKA, AL 36801

HOME PHONE: 334-524-7600

DOB: 08/28/1965 AGE: 37

PLCE BIRTH: INDIANAPOLLIS

STATE: IN

M. STATUS: MARRIED

RELIGION: CHRISTIAN

GANG ASSOC: NONE

SCARS/TATTOOS: NONE

KNOWN ENEMIES: NONE

REMARKS: NONE

RACE: B SEX: M

HT: 6'01" HAIR: BLK

WT: 255 EYES: BRO

COMPLEX:

SSN: 012-00-0000

DL ST: AL

DLN: 10120000

SID:

LOCID: 3823

NEXT OF KIN

NEXT OF KIN: BARBARA SANFORD

ADDRESS: SAA

CITY/ST/ZIP: ,

REMARKS:

RELATIONSHIP: WIFE

PHONE: 000-000-0000

EMPLOYER INFO

EMPLOYED: Y

EMPLOYER NAME: SANFORD & SON'S CONTRACTOR

ADDRESS:

CITY/ST/ZIP: OPELIKA, AL 36801

PHONE: 334-524-7600

MEDICAL

HANDICAPPED: Y NEEDS:

GLASSES: N SMOKE: N

MEDICAL NEEDS: N NEEDS: N

PHYSICIAN:

PHONE: 000-000-0000

REMARKS: FRACTURED WRIST,

REMARKS: ALLERGENIC TO PENNCILLIN, WASP STINGS, BEE STINGS

REMARKS:

PROPERTY

CASH: \$00.00

DESCRIPTION:

DD. PROPERTY: PAPERS, BLK BILLFOLDER W/CONTENTS, DU-RAG, KEYS

DD. PROPERTY:

DD. PROPERTY:

BIN NUMBER: WHIT BAG

EH IMPOUNDED:

IMPOUND LOT:

REMARKS:

REMARKS:

HAVE READ THE ABOVE ACCOUNTING OF MY PERSONAL INFORMATION, MEDICAL
INFORMATION, MONEY, AND OTHER PROPERTY AND I FIND IT TO BE TRUE AND ACCURATE.

INMATE: [Signature] DATE: _____ TIME: _____BOOK OFFICER: [Signature] DATE: _____ TIME: _____

LEE COUNTY SHERIFF'S OFFICE
MEDICAL SCREENING FORM

07/18/2003 14:15:30

PAGE 1

Booking No: 030003117 Date: 07/18/2003 Time: 13:56 Type: NORMAL
 Agency to Bill: LEE COUNTY Facility: COUNTY JAIL

Inmate Name: SANFORD JEFFERY BERNARD Race: B Sex: M
 DOB: [REDACTED] Age: 37 SSN: [REDACTED] Height: 6'01" Weight: 255

- N 1. Is inmate unconscious?
2. Does inmate have any visible signs of trauma, illness, obvious pain and bleeding, requiring immediate emergency or doctor's care?
3. Is there obvious fever, swollen lymph nodes, jaundice or other evidence of infection that might spread through the facility?
4. Any signs of poor skin condition, vermin, rashes or needle marks?
5. Does inmate appear to be under the influence of drugs or alcohol?
6. Any visible signs of alcohol or drug withdrawal?
7. Does inmate's behavior suggest the risk of suicide or assault?
8. Is inmate carrying any medication?
9. Does the inmate have any physical deformities?
10. Does inmate appear to have psychiatric problems?
11. Do you have or have you ever had or has anyone in your family ever had any of the following?
- | | | |
|-----------------------|----------------------------------|------------------------------|
| <u>Y</u> a. Allergies | <u>N</u> f. Fainting Spells | <u>N</u> k. Seizures |
| <u>N</u> b. Arthritis | <u>N</u> g. Hearing Condition | <u>N</u> l. Tuberculosis |
| <u>N</u> c. Asthma | <u>N</u> h. Hepatitis | <u>N</u> m. Ulcers |
| <u>N</u> d. Diabetes | <u>N</u> i. High Blood Pressure | <u>N</u> n. Venereal Disease |
| <u>N</u> e. Epilepsy | <u>N</u> j. Psychiatric Disorder | <u>N</u> o. Other (Specify) |

Other: ~~Broken~~ Fractured wrist / rt.

12. For females only:

- a. Are you pregnant?
- b. Do you take birth control pills?
- c. Have you recently delivered?

LEE COUNTY SHERIFF'S OFFICE

INMATE BOOKING SHEET

PAGE 1

02/01/2006 10:38:42

BOOKING NO: 060000564

INMATE NAME: SANFORD JEFFERY BERNARD

ALIAS:

ALIAS:

ADDRESS: 200 BORDEN CT #510

CITY/ST/ZIP: OPELIKA, AL 36801

HOME PHONE: 000-000-0005

DOB: 07/06/1965 AGE: 40

PLCE BIRTH: INDIANAPOLLIS

STATE: IN

M. STATUS: SINGLE

RELIGION: CHRISTIAN

GANG ASSOC: NONE

SCARS/TATTOOS: NONE

KNOWN ENEMIES: NONE

REMARKS: NONE

RACE: B SEX: M

HT: 6'01" HAIR: BLK

WT: 255 EYES: BRO

COMPLEX:

SSN: [REDACTED]

DL ST: AL DLN: [REDACTED]

SID:

LOCID: 3823

----- NEXT OF KIN -----

NEXT OF KIN: JOAN FOREMAN

ADDRESS: SAA

CITY/ST/ZIP: ,

REMARKS:

RELATIONSHIP: FRIEND

PHONE: 000-864-0973

----- EMPLOYER INFO -----

EMPLOYED: N

EMPLOYER NAME: SOUTHERN UNION

ADDRESS:

CITY/ST/ZIP: OPELIKA, AL 36801

PHONE: 334-745-0325

----- MEDICAL -----

HANDICAPPED: Y NEEDS:

GLASSES: N SMOKE: N

MEDICAL NEEDS: N NEEDS: N

PHYSICIAN:

PHONE: 000-000-0000

REMARKS: FRACTURED WRIST,

REMARKS: ALLERGEIC TO PENNCILLIN, WASP STINGS, BEE STINGS

REMARKS:

----- PROPERTY -----

CASH: \$00.00

DESCRIPTION:

ADD. PROPERTY: WALLET, BELT, HAT, JACKET, DU RAG,

ADD. PROPERTY:

ADD. PROPERTY:

BIN NUMBER: 193

VEH IMPOUNDED:

IMPOUND LOT:

REMARKS:

REMARKS:

=====

I HAVE READ THE ABOVE ACCOUNTING OF MY PERSONAL INFORMATION, MEDICAL INFORMATION, MONEY, AND OTHER PROPERTY AND I FIND IT TO BE TRUE AND ACCURATE.

INMATE: [Signature]

DATE: _____ TIME: _____

BOOK OFFICER: [Signature]

DATE: 2-1-06 TIME: 1040

LEE COUNTY SHERIFF'S OFFICE
MEDICAL SCREENING FORM

PAGE 1

02/01/2006 10:38:42

Booking No: 060000564 Date: 02/01/2006 Time: 10:29 Type: NORMAL
 Agency to Bill: LEE COUNTY Facility: COUNTY JAIL

Inmate Name: SANFORD JEFFERY BERNARD Race: B Sex: M
 DOB: [REDACTED] Age: 40 SSN: [REDACTED] Height: 6'01" Weight: 255

- N 1. Is inmate unconscious?
- N 2. Does inmate have any visible signs of trauma, illness, obvious pain and bleeding, requiring immediate emergency or doctor's care?
- N 3. Is there obvious fever, swollen lymph nodes, jaundice or other evidence of infection that might spread through the facility?
- N 4. Any signs of poor skin condition, vermin, rashes or needle marks?
- N 5. Does inmate appear to be under the influence of drugs or alcohol?
- N 6. Any visible signs of alcohol or drug withdrawal?
- N 7. Does inmate's behavior suggest the risk of suicide or assault?
- N 8. Is inmate carrying any medication?
- N 9. Does the inmate have any physical deformities?
- N 10. Does inmate appear to have psychiatric problems?
11. Do you have or have you ever had or has anyone in your family ever had any of the following?
- | | | |
|-------------------------|-----------------------------------|------------------------------|
| <u>Yes</u> a. Allergies | <u>N</u> f. Fainting Spells | <u>N</u> k. Seizures |
| <u>N</u> b. Arthritis | <u>N</u> g. Hearing Condition | <u>N</u> l. Tuberculosis |
| <u>N</u> c. Asthma | <u>N</u> h. Hepatitis | <u>Yes</u> m. Ulcers |
| <u>Yes</u> d. Diabetes | <u>Yes</u> i. High Blood Pressure | <u>N</u> n. Venereal Disease |
| <u>N</u> e. Epilepsy | <u>N</u> j. Psychiatric Disorder | <u>N</u> o. Other (Specify) |

Other: _____

12. For females only:

- N a. Are you pregnant?
- N b. Do you take birth control pills?

LEE COUNTY SHERIFF'S OFFICE
MEDICAL SCREENING FORM

02/01/2006 10:38:42

PAGE 2

Booking No: 060000564 Date: 02/01/2006 Time: 10:29 Type: NORMAL
Agency to Bill: LEE COUNTY Facility: COUNTY JAIL

Inmate Name: SANFORD JEFFERY BERNARD Race: B Sex: M
DOB: [REDACTED] 65 Age: 40 SSN: [REDACTED] 5 Height: 6'01" Weight: 255

- YES 13. Have you recently been hospitalized or treated by a doctor?
- YES 14. Do you currently take any non-prescription medication or medication prescribed by a doctor?
- YES 15. Are you allergic to any medication?
- N 16. Do you have any handicaps or conditions that limit activity?
- N 17. Have you ever attempted suicide or are you thinking about it now?
- N 18. Do you regularly use alcohol or street drugs?
- N 19. Do you have any problems when you stop drinking or using drugs?
- N 20. Do you have a special diet prescribed by a physician?
- N 21. Do you have any problems or pain with your teeth?
- YES 22. Do you have any other medical problems we should know about?

Penialin
colon Cancer -

HAVE READ THE ABOVE ACCOUNTING OF MY MEDICAL ASSESSMENT AND I FIND IT TO BE TRUE AND ACCURATE.

INMATE: [Signature] DATE: _____ TIME: _____
BOOK OFFICER: [Signature] DATE: _____ TIME: _____

LEE COUNTY SHERIFF'S OFFICE
INMATE BOOKING SHEET

07/18/2003 14:15:28

PAGE 1

BOOKING NO: 030003117

INMATE NAME: SANFORD JEFFERY BERNARD

ALIAS:

ALIAS:

ADDRESS: [REDACTED] #510

CITY/ST/ZIP: OPELIKA, AL 36801

HOME PHONE: [REDACTED] 5

DOB: [REDACTED] AGE: 37

PLCE BIRTH: INDIANAPOLLIS

STATE: IN

M. STATUS: MARRIED

RELIGION: CHRISTIAN

GANG ASSOC: NONE

SCARS/TATTOOS: NONE

KNOWN ENEMIES: NONE

REMARKS: NONE

RACE: B SEX: M

HT: 6'01" HAIR: BLK

WT: 255 EYES: BRO

COMPLEX:

SSN: [REDACTED]

DL ST: AL DLN: 3 [REDACTED]

SID:

LOCID: 3823

NEXT OF KIN

NEXT OF KIN: BARBARA SANFORD

ADDRESS: SAA

CITY/ST/ZIP: ,

REMARKS:

RELATIONSHIP: WIFE

PHONE: 000-000-0000

EMPLOYER INFO

EMPLOYED: Y

EMPLOYER NAME: SANFORD & SON'S CONTRACTOR

ADDRESS:

CITY/ST/ZIP: OPELIKA, AL 36801

PHONE: 334-524-7600

MEDICAL

HANDICAPPED: Y NEEDS:

GLASSES: N SMOKE: N

MEDICAL NEEDS: N NEEDS: N

PHYSICIAN:

PHONE: 000-000-0000

REMARKS: FRACTURED WRIST,

REMARKS: ALLERGENIC TO PENNCILLIN, WASP STINGS, BEE STINGS

REMARKS:

PROPERTY

CASH: \$00.00

DESCRIPTION:

DD. PROPERTY: PAPERS, BLK BILLFOLDER W/CONTENTS, DU-RAG, KEYS

DD. PROPERTY:

DD. PROPERTY:

BIN NUMBER: WHIT BAG

EH IMPOUNDED:

IMPOUND LOT:

REMARKS:

REMARKS:

HAVE READ THE ABOVE ACCOUNTING OF MY PERSONAL INFORMATION, MEDICAL
INFORMATION, MONEY, AND OTHER PROPERTY AND I FIND IT TO BE TRUE AND ACCURATE.

INMATE: [Signature] DATE: _____ TIME: _____

BOOK OFFICER: [Signature] DATE: _____ TIME: _____

07/18/2003 14:15:30

LEE COUNTY SHERIFF'S OFFICE
MEDICAL SCREENING FORM

PAGE 1

Booking No: 030003117 Date: 07/18/2003 Time: 13:56 Type: NORMAL
 Agency to Bill: LEE COUNTY Facility: COUNTY JAIL

Inmate Name: SANFORD JEFFERY BERNARD Race: B Sex: M
 DOB: 12/30/1969 Age: 37 SSN: 3- [REDACTED] Height: 6'01" Weight: 255

- m
1. Is inmate unconscious?
 2. Does inmate have any visible signs of trauma, illness, obvious pain and bleeding, requiring immediate emergency or doctor's care?
 3. Is there obvious fever, swollen lymph nodes, jaundice or other evidence of infection that might spread through the facility?
 4. Any signs of poor skin condition, vermin, rashes or needle marks?
 5. Does inmate appear to be under the influence of drugs or alcohol?
 6. Any visible signs of alcohol or drug withdrawal?
 7. Does inmate's behavior suggest the risk of suicide or assault?
 8. Is inmate carrying any medication?
 9. Does the inmate have any physical deformities?
 10. Does inmate appear to have psychiatric problems?
 11. Do you have or have you ever had or has anyone in your family ever had any of the following?

- | | | |
|-----------------------|----------------------------------|------------------------------|
| <u>Y</u> a. Allergies | <u>N</u> f. Fainting Spells | <u>N</u> k. Seizures |
| <u>N</u> b. Arthritis | <u>N</u> g. Hearing Condition | <u>N</u> l. Tuberculosis |
| <u>N</u> c. Asthma | <u>N</u> h. Hepatitis | <u>N</u> m. Ulcers |
| <u>N</u> d. Diabetes | <u>N</u> i. High Blood Pressure | <u>N</u> n. Venereal Disease |
| <u>N</u> e. Epilepsy | <u>N</u> j. Psychiatric Disorder | <u>N</u> o. Other (Specify) |

Other: Broken Fractured wrist / rt.

12. For females only:

- a. Are you pregnant?
- b. Do you take birth control pills?
- c. Have you recently delivered?

F-4
LOCATION

Name Jeff Sanford Date 4-2-06 **LOCATION**
☐ Telephone Call ☐ Doctor ☐ Dentist ☐ Time Sheet
☐ Special Visit ☐ Personal Problem ☒ Other Nurse

I really need some packs of
Triple Antibiotic Ointment to
heal a scar I have on my
leg. Thank you!

4/4/00 seen on sick calf today
B. Luff

All Request Will Be Routed Through The Sergeant Over The Jail, Then Forwarded To Those The Request is Directed.

CORRECTION OFFICER _____

DATING FOR		THROUGH	
Physician		Telephone No.	
Physician		Alt. Telephone	
Address		Rehabilitative Potential	
Notes			
Insurance		Approved By Doctor:	
Insurance		By:	
Insurance		Title:	
Insurance		Date:	
IDENT		D.O.B.	
IDENT		Sex	
IDENT		Room #	
IDENT		Patient Code	
IDENT		Admission Date	

LEE COUNTY DETENTION CENTER MEDICAL CHARGE FORM (FORM #33)

INMATE NAME Sanford, Jeffery
DATE OF BIRTH [REDACTED] RACE/SEX B/m
SOCIAL SECURITY# [REDACTED] CELL F-4

SERVICES & FEES

- ☐ SICK CALL
- ☐ DOCTOR VISIT
- ☐ DENTIST VISIT
- ☒ PRESCRIPTION
- ☐ FOLLOW-UP VISIT

\$10.00

\$10.00

\$10.00

\$3.00

N/A

Flagyl
Naprosyn
Flexeril

TOTAL OF MEDICAL SERVICES
RENDERED

\$ 9.00

MEDICAL VERIFICATION SECTION

Authorized Nursing Staff Signature & Date

[Signature] 4/1/06

Inmate Signature & Date

[Signature]

Inmate Account Payable Clerk Signature & Date

[Signature]

☐ PLEASE CHECK IF INMATE IS INDIGENT TO PAY THE ABOVE CHARGES.

☐ PLEASE CHECK IF INMATE IS ABLE TO PAY THE ABOVE CHARGES.

Lee County Detention Center
INMATE REQUEST SLIP

F-6

LOCATION

Name JEFFERY B. SANFORD Date 5-13-06

☐ Telephone Call ☐ Doctor ☐ Dentist ☐ Time Sheet
☐ Special Visit ☐ Personal Problem ☒ Other

Briefly Outline Your Request. Give To Jailer

REQUEST FOR TOOTH-ACHE MED.
PLEASE CONSIDER, IN PAIN.
ORAGEL OR AMBROL

THANK YOU

Do Not Write Below This Line - For Reply Only

5/14/06 Tylenol + Oragel sent

Nurse Griffith

Approved _____ Denied _____ Collect Call _____

All Request Will Be Routed Through The Sergeant Over The Jail, Then Forwarded To Those The Request is Directed.

☐ Lieutenant ☐ Chief Deputy ☐ Sheriff

Date _____ Time Received _____

CORRECTION OFFICER _____

County Detention Center
INMATE REQUEST SLIP

(MS. STEWART)

F-6

LOCATION

Name JEFFERY B. SANFORD Date 5-16-06

☐ Telephone Call ☐ Doctor ☐ Dentist ☐ Time Sheet
☐ Special Visit ☒ Personal Problem ☐ Other

Briefly Outline Your Request. Give To Jailer

(MS. STEWART)

COULD I PLEASE HAVE SOMETHING
TO TAKE FOR A TOOTH-ACHE, PLEASE!
AS SOON AS POSSIBLE

THANK YOU.

Do Not Write Below This Line - For Reply Only

5/17/06 # motor given

Nurse Stewart

Approved _____ Denied _____ Collect Call _____

All Request Will Be Routed Through The Sergeant Over The Jail, Then Forwarded To Those The Request is Directed.

☐ Lieutenant ☐ Chief Deputy ☐ Sheriff

Date _____ Time Received _____

SECTION OFFICER _____

ee County Detention Center
INMATE REQUEST SLIP

MS. STEWART OR MS. GRIFFIN F-6

LOCATION

Name JEFFERY B. SANFORD Date 5-17-06

☐ Telephone Call ☐ Doctor ☐ Dentist ☐ Time Sheet
☐ Special Visit ☒ Personal Problem ☐ Other

Briefly Outline Your Request. Give To Jailer

MAY I PLEASE HAVE SOMETHING TODAY
TO TAKE FOR VERY BAD TOOTH ACHE,
AND AN APPOINTMENT TO SEE ONE OF
THE NURSES CONCERNING SOME TYPE OF
PRESCRIPTION FOR PAIN UNTIL TOOTH IS
REMOVE. PLEASE CONSIDER

THANK YOU.

Do Not Write Below This Line - For Reply Only

5/17/06 it typ sent you
have asked you saw
our dentist "you're down
to see oral surgeon !!!

Nurse Stewart

Approved _____ Denied _____ Collect Call _____

All Request Will Be Routed Through The Sergeant Over The Jail, Then Forwarded To Those The Request is Directed.

☐ Lieutenant ☐ Chief Deputy ☐ Sheriff

Date _____ Time Received _____

CORRECTION OFFICER _____